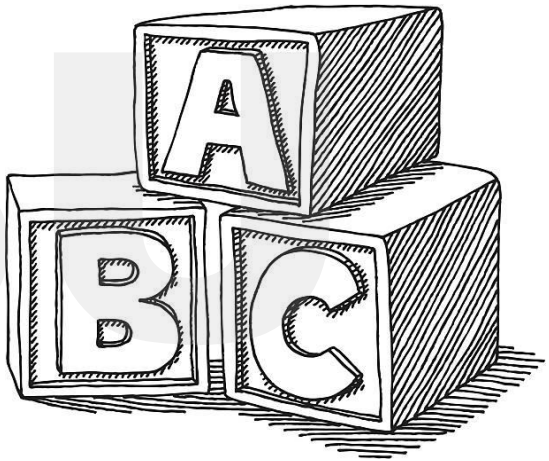


# Effective Counseling for Common Behavioral Concerns in Early Childhood

## Guiding Principles and Specific Strategies

American Academy of Pediatrics Developmental-Behavioral Pediatrics Virtual Course
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# Disclosure

- I have no financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

# Learning Objectives

1. Establish the importance of early childhood behavioral health.
2. Describe caregivers' priorities and preferences for behavioral guidance.
3. Articulate guiding principles and specific strategies for effectively managing common behavior concerns.
4. Describe a decision framework for selective effective intervention components.

# What we're doing isn't working

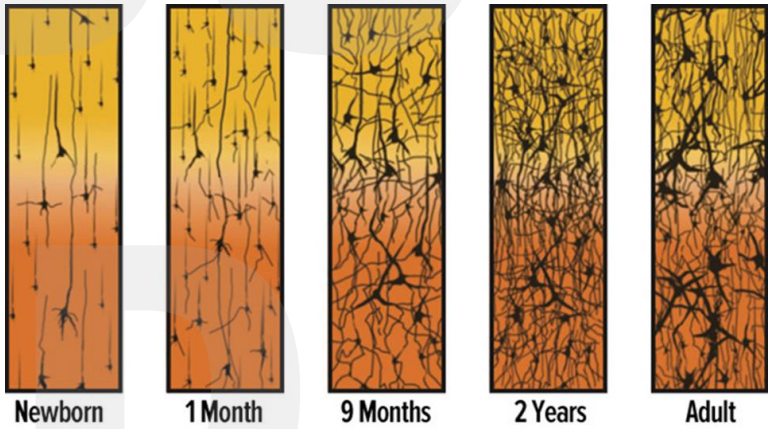
- Population mental health is getting worse.
  - 1/5 youth meet criteria for mental disorder; 2/5 will by age 18
    - Additional 40% experience distress or impairment
  - 3/5 teen girls feel persistently sad or hopeless
  - Youth suicide increased 29% over last decade
- Mental health service access is poor.
  - <50% referred to MH services will access them
  - Most needy are the least likely to access services
  - Nationwide shortage of MH professionals



Merikangas et al., 2011; Sheldrick et al., 2011, *Pediatrics;* Stein et al, 2016, *Academic Pediatrics*, Taylor et al., 2013, *Clinical Pediatrics;* CDC, 2023

# An ounce of prevention…

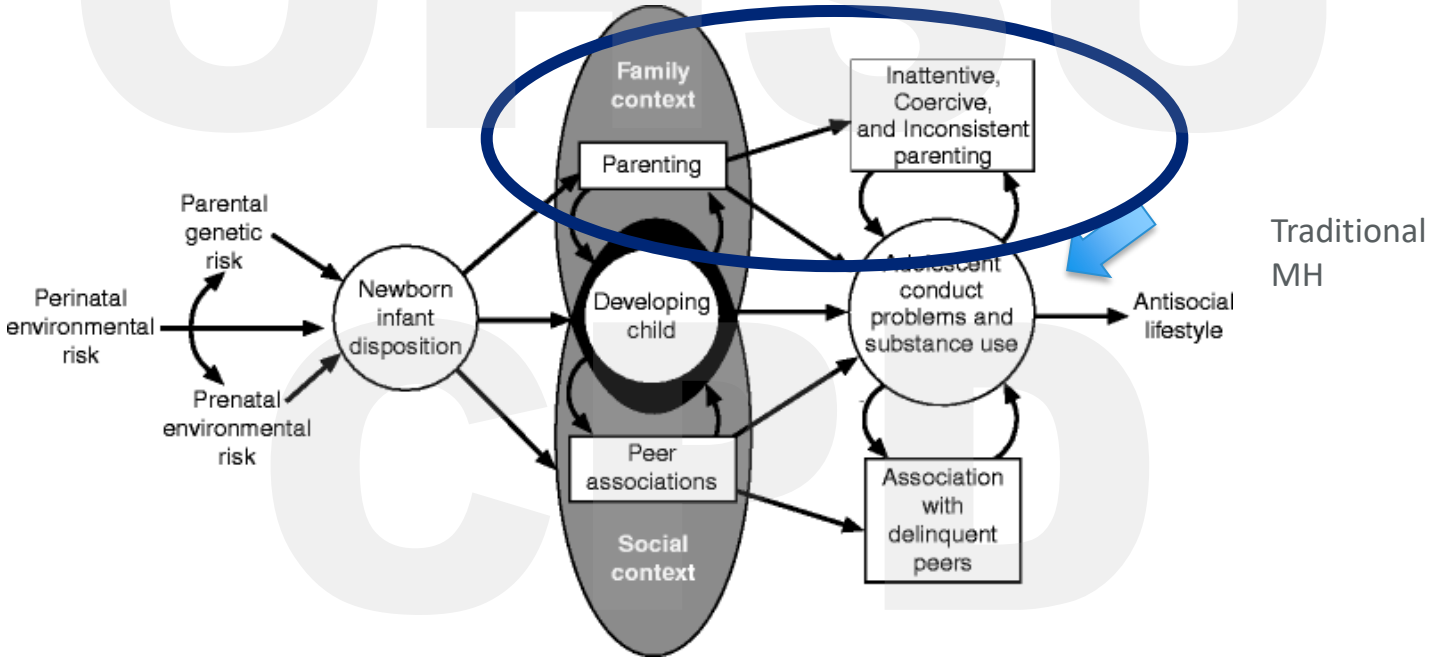
- Most adult mental health disorders begin in childhood
- 80% of synaptic connections are made by age 3
- Early childhood adversity and chronic stress have lifelong impacts
- Early/preventative interventions produce  much larger return on investment






Shonkoff et al., 2012, *Pediatrics;* Racine, 2016, *The Economics of Child Development;* Bruner & Hayes, *Health Affairs,* 2023

# Parenting is a Critical and Modifiable




Traditional MH



Dynamic developmental systems model of conduct problems (Capaldi & Eddy 2005)

# Primary Care is the *de facto* MH System in the US

- Social and behavioral health problems are the "new morbidity" of pediatric health.
- PCPs are the most likely source of professional help
  - 50–80% of all child medical visits
  - Primary concern in 15-20%
- Primary care offers early identification/intervention in a trusted environment, but PCPs face significant barriers:
  - Time
  - Training
  - Resources
  - Financial incentive



Embry & Biglan, 2008, *Clinical Child and Family Psych Rev;* Williams et al., 2004, *Pediatrics;* Meadows et al., 2011

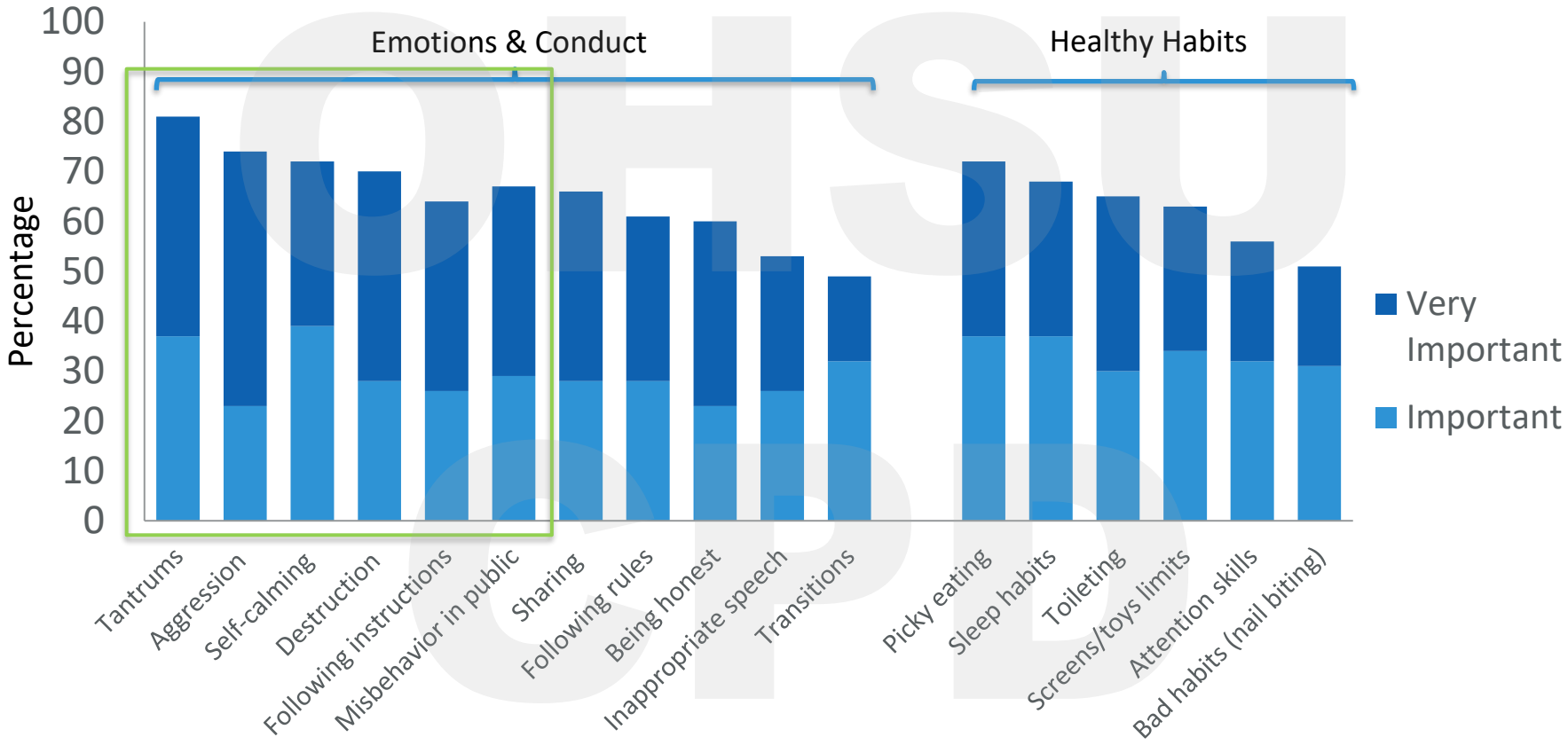
# Social-Emotional Health Incentive Metric

- Beginning 2025, Oregon CCOs are incentivized to provide social-emotional intervention services for children 1-5 years
- The metric generally does not target PCP-delivered services, but CCOs may choose to incentivize
  - Early childhood social-emotional screening
  - Referral coordination
  - Integrated behavioral health services
- https://oregon-pip.org/health-aspects-of-kindergarten-readiness/proposed-2025-child-level-metric-focused-on-issue-focused-interventions-addressing-young-childrens-social-emotional-health/



OPIP
Oregon Pediatric Improvement Partnership

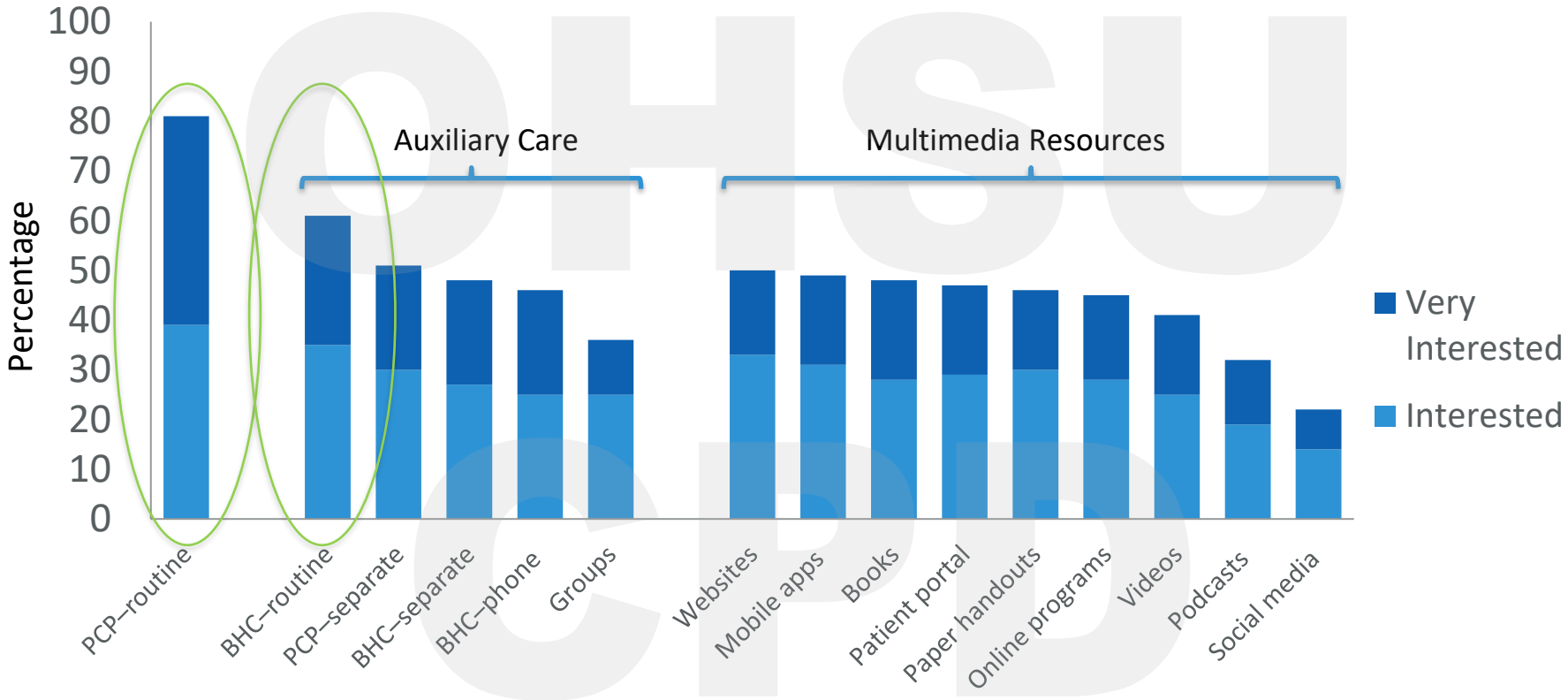
# Parent-Rated Importance of topics as part of primary care (N=396)






Riley et al., 2019, *Journal of Developmental & Behavioral Pediatrics*

# Parent-Rated Interest in Delivery Methods (N=396)






Riley et al., 2019, *Journal of Developmental & Behavioral Pediatrics*

# Parent Perspectives

It's not necessarily their education or how much they know or anything, but the fact that they have to see twelve people in an hour or whatever it is. I think the doctors need more time to make the parents feel like we're getting enough time.

I know giving positive praise. I know doing sticker charts. I know all of that stuff. This is different... It's always like a running joke, "Oh, she's strong-willed. Ha ha ha."

They always seem to have this broad advice… "Take your kid out of the environment, give them choices." Sometimes those things, those are like your three answers or whatever. They don't work for what's going on.



Riley et al. (2022). *The Journal of Behavioral Health Services & Research.*

- **The Challenge**
  - Behavioral issues are disproportionately time-consuming
  - Parents often experience frontline information as “too basic”

- **The Strategy**
  - Normalize and empathize
  - Utilize well-established principles of behavior
  - Model the skills you hope to impart
  - Communicate digestibly and memorably

# Guiding Principles for Better Behavior

## Principle # 1: Teach, Don't Preach


"Knowing" ≠ Learning

- Knowledge is potentially useful, but often insufficient (and unnecessary) for behavior change
- Reasoning alone often results in worse behavior over time.
- Consider adult health behaviors

- How can we best teach?
  - Variation and selection

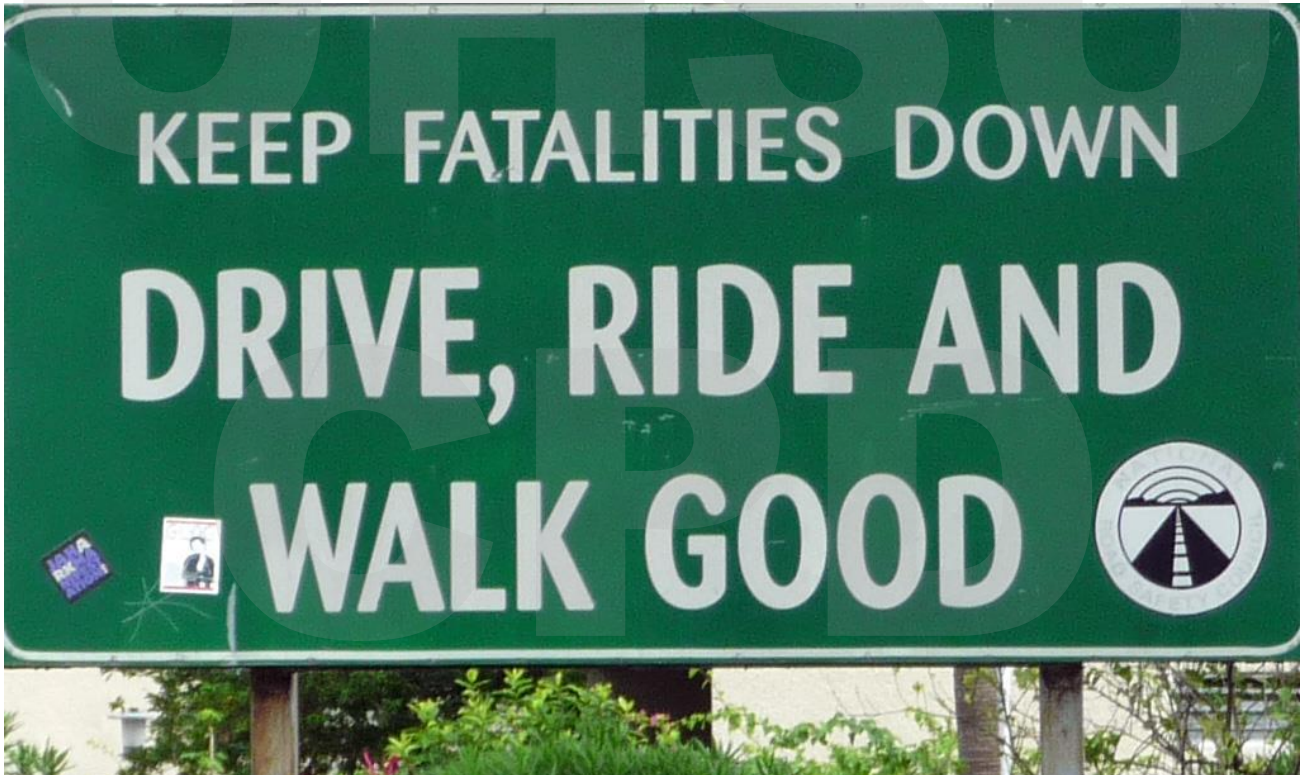
Teaching is about
variation and selection

# Guiding Principles for Better Behavior

## Principle # 2: Don’t Make them Guess

# Guiding Principles for Better Behavior

## Principle # 2: Don’t Make them Guess



# Guiding Principles for Better Behavior

## Principle # 3: Create Contrast (Kansas or Oz?)


(A - C) x Repetition = Learning


GIF.TV


GIF.TV


GIF.TV

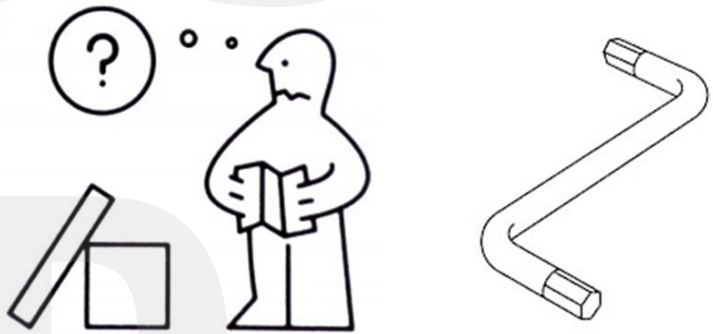

GIF.TV


GIF.TV

See: *Giving Great Instructions* handout/video.

# Common Issue #1:

- *Presentation:* Failure to follow instructions
- *Critical issue:* Parents may give instructions that are vague or overly complex
- *Goal:* Promote effective instruction delivery to increase the rate of cooperation.
- *Intervention:* Effective Instructions (don't make them guess)





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# Suboptimal vs Optimal Instructions

1. Yelling across the room
2. Are you ready to pick up?
3. Stop that!
4. Behave yourself
5. Sing-songy or harsh
6. Take compliance for granted

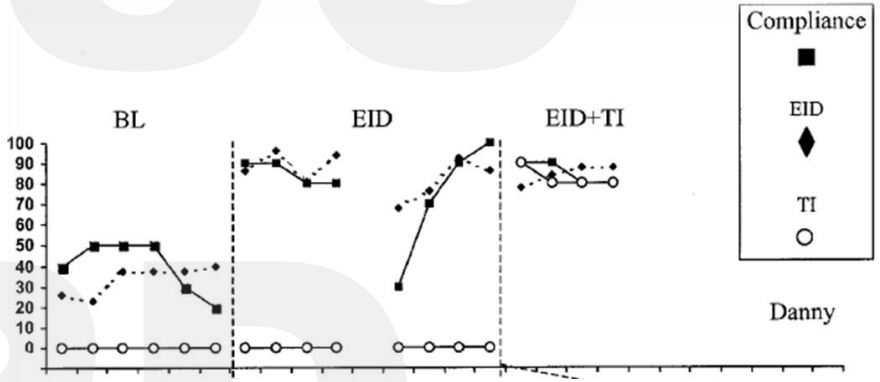
1. Secure Attention (eye contact)
2. Use an imperative, don't ask
3. State what *to do*
4. Specific
5. Polite but Firm
6. Praise Compliance

Okay, are you ready to start taking care of these toys so we can get your backpack ready and you can go home?

→ Please pick up your toys.

# Evidence for Effective Instructions

- Common component of different empirically supported treatment packages
- Evidence as stand-alone treatment across settings and developmental levels
- Individual components matter
- Can be taught quickly






Benoit et al. (2001). *Child & Family Behavior Therapy.* Everett et al. (2005). *Education and Treatment of Children.* Ford et al. (2001). *School Psychology Quarterly.* Mandal et al. (2000). *Child & Family Behavior Therapy.* Riley et al. (2016). *Clinical Practice in Pediatric Psychology.* Stephenson & Hanley (2010). *Journal of Applied Behavior Analysis.*

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See: *3-Step Prompting* handout.

# Variation: 3-Step Prompting

- Step 1 – Verbal Instruction
  - Wait 10 seconds for compliance
  - Compliance -> Praise
  - No compliance -> Step 2
  - Don't repeat the Instruction a second time
- Step 2 – Model or Gesture (+ Verbal)
  - Wait 10 seconds for compliance
  - Compliance -> Praise
  - No compliance -> Step 2
  - Don't repeat the prompt a second time
- Step 3 – Physical Guidance (+ Verbal)
  - Use whatever level of prompt is necessary for success
  - Match level of praise to skill-level
  - Start over for practice

See: *Paying Attention, So Attention Pays Off, Power of Praise,* and *Figuring Out Frustration* handouts/videos

# Common Issue #2:

- *Presentation*: "Upset and obnoxious" behavior (e.g., screaming, whining, excessive crying, cursing, name calling)
- *Critical issue*: Inadvertent positive reinforcement via contingent attention - attempts to persuade, soothe, threaten, cajole, etc., backfire and maintain misbehavior
- *Goal*: Direct parental attention to appropriate behavior while minimizing attention for misbehavior
- *Intervention*: Selective Attention/Strategic Ignoring (create contrast)

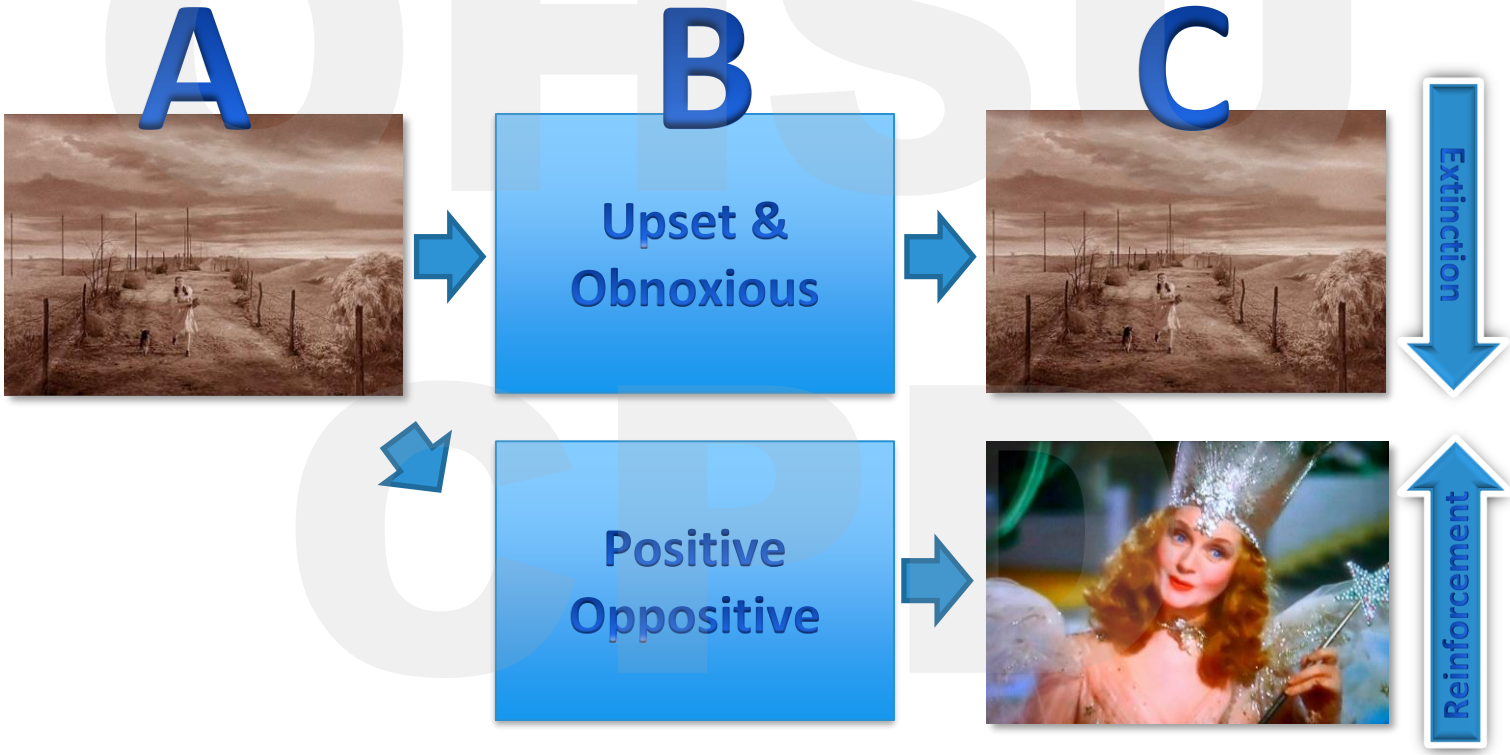
A

B

Upset &
Obnoxious

C

Reinforcement


A
B
C
Upset &
Obnoxious
Extinction
Positive
Oppositive
Reinforcement

# Selective Attention/Strategic Ignoring

- Negative attention is like fast food: You'd probably rather have a well-cooked meal, but it'll do when you have a craving. And, if you have it too much, you might develop an appetite for it.

- Behavioral Keys: Kids are trying to unlock your attention. It's up to you to make sure they find the right key.

- Great combo with Effective Instructions!



Ducharme JM, Popynick M. Errorless compliance to parental requests: Treatment effects and generalization. Behavior Therapy. 1993;24(2):209-26.

# Notes on Ignoring

- Ignore behaviors, not children
  - It is possible to be physically and emotionally present while ignoring misbehavior
- Ignoring maybe be passive or active
  - Passive – Acting as if the behavior didn't happen
  - Active – Withdrawing attention (e.g., turning away)
- Depending on history, ignoring may result in a significant *extinction burst*
  - To be effective, ignoring must continue. Consider tolerability.
  - If ignoring is untenable, redirecting to a more appropriate behavior via Effective Instructions is a great 2nd option.

See: *Tips on Timeout* handout/video.

# Common Issue #3

- *Presentation:*
  - "Dangerous & destructive" behavior that cannot be safely ignored (e.g., aggression, destruction, unsafe behavior, persistent noncompliance)
  - Parents who use corporal punishment or other harsh methods

- *Critical issue:* Many have tried "time-out" and found it doesn't work.
  - 85% implement time-out sub-optimally

- *Goal:* Teach or refine time-out procedures to make them more effective by maximizing contrast

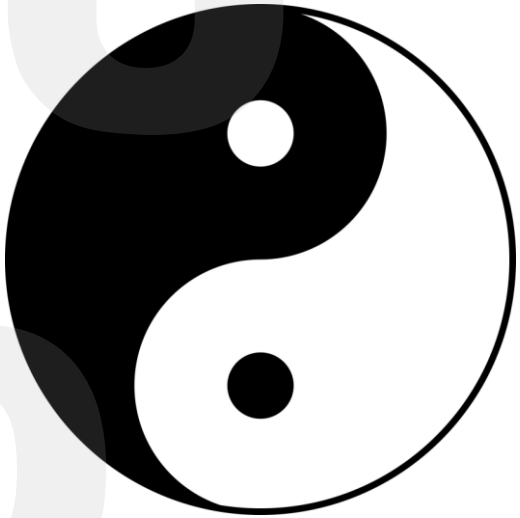
- Intervention: Time-Out and the 2 Kinds of Nothing




Riley, A. R., Wagner, D. V., Tudor, M. E., Zuckerman, K. E., & Freeman, K. A. (2017). A Survey of Parents' Perceptions and Use of Time-out Compared to Empirical Evidence. Acad Pediatr, 17(2), 168-175. https://doi.org/10.1016/j.acap.2016.08.004

# Understanding Time-Out

- *Time-Out from opportunity for positive reinforcement (Time-In)*
- Not a single technique, but a concept
- Time-Out is effective when you have “Two Kinds of Nothing”



# Nothing going on

Nothing going on
Nothing they can do about it



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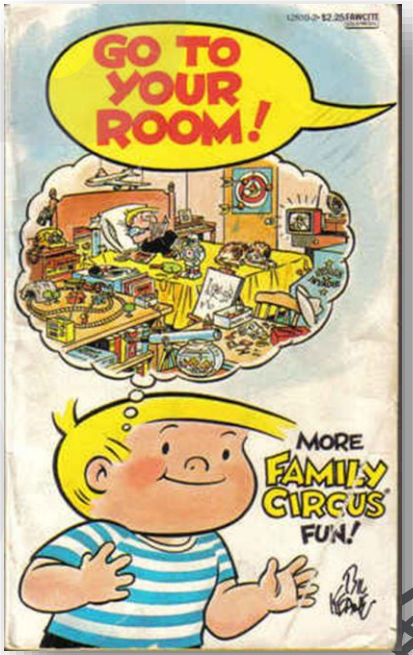
# Prototype Time-Out

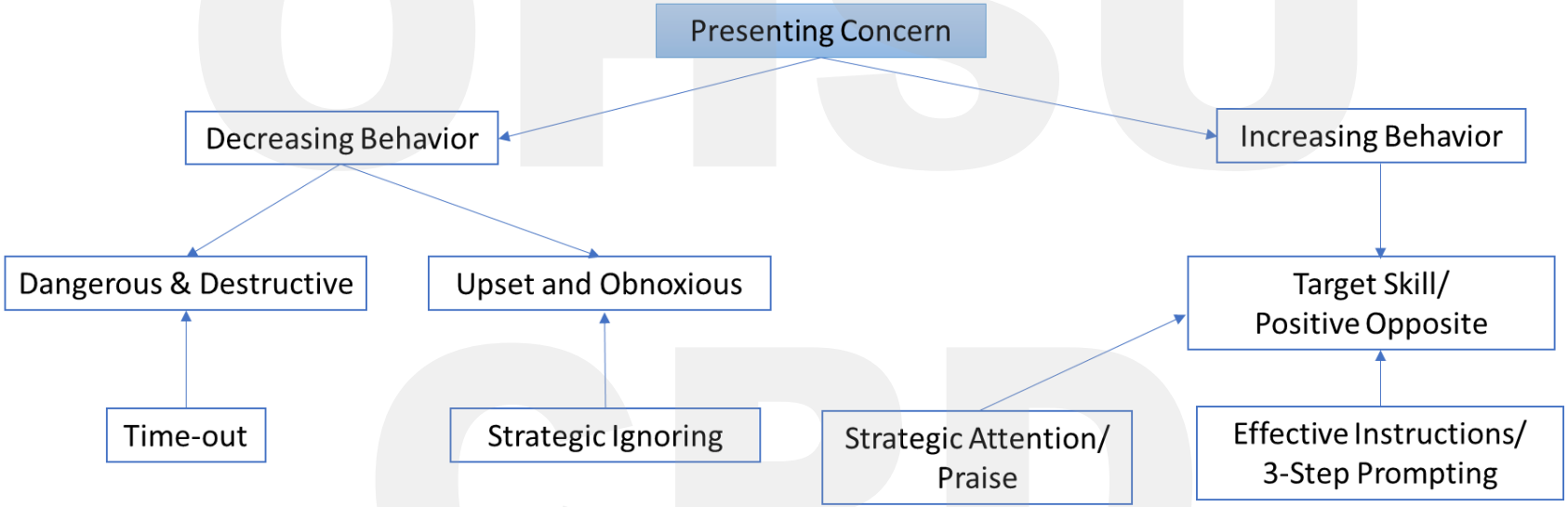
- When to do Time-Out (TO)
  - Immediately after misbehavior
- Where to do TO
  - Quiet corners/wall spaces, hallways, bottom steps of stairwells, or dining tables often work well
  - Adult size chair or other physically defined space is useful (e.g., small rug or towel)
  - Toddlers can often just be turned away from their parent on the floor or placed in playpen
- Beginning TO
  - Single, brief, unemotional warning (e.g., “You’re not listening. If you don’t do what I say, that’s timeout”).
  - Quickly label the misbehavior (e.g., “No hitting, that’s time-out”).
  - Send or escort the child to the TO area with as little interaction as possible.
- During TO
  - Restrict access to any activities, objects, or attention.
  - Ignore anything the child as long as they remain safe and in the TO area.
- Ending TO
  - 2 minutes is usually sufficient for preschool ages and 30 seconds may be sufficient for toddlers
  - Require a short period (10-15 seconds) of calm before ending the TO.
  - Signal the end of the TO with a brief explanation (e.g., “You’re being calm, so time-out is over. You were in time-out because you hit”).
  - If the TO was given for noncompliance, reissue the initial instruction.
- After TO
  - Praise appropriate behavior as soon as possible.

# We Tried that and it Didn't Work!

- Is there sufficient positive reinforcement (Time-In) in place?
- Is there something going on?
- Is there something he/she can do about it?
- Escape from TO is most likely reason for ineffectiveness
  - Persistence
  - Shorter TO interval to start
  - Back-up space
  - Deferred TO



# Framework for Counseling Common Behavior Issues



# Final Thoughts

- Parents greatly value conversations about behavior with PCPs.
- Trust the fundamentals: Variation and selection!
- Normal parenting is tough! When in doubt, listen and empathize.





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# Thank You

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# References


Benoit, D. A., Edwards, R. P., Olmi, D. J., Wilczynski, S. M., & Mandal, R. L. (2001). Generalization of a positive treatment package for child noncompliance. *Child & Family Behavior Therapy*, *23*(2), 19-32.

Bitsko, R. H., Claussen, A. H., Lichstein, J., Black, L. I., Jones, S. E., Danielson, M. L., Hoenig, J. M., Davis Jack, S. P., Brody, D. J., Gyawali, S., Maenner, M. J., Warner, M., Holland, K. M., Perou, R., Crosby, A. E., Blumberg, S. J., Avenevoli, S., Kaminski, J. W., Ghandour, R. M., & Meyer, L. N. (2022). Mental Health Surveillance Among Children — United States, 2013–2019. *MMWR Supplements*, *71*(2), 1-42. https://doi.org/10.15585/mmwr.su7102a1

Combs-Orme, T., Holden Nixon, B., & Herrod, H. G. (2011). Anticipatory guidance and early child development: pediatrician advice, parent behaviors, and unmet needs as reported by parents from different backgrounds. *Clin Pediatr (Phila)*, *50*(8), 729-737. https://doi.org/10.1177/0009922811403302

Costello, E. J., & Shugart, M. A. (1992). Above and below the threshold: severity of psychiatric symptoms and functional impairment in a pediatric sample. *Pediatrics*, *90*(3), 359-368.

Ducharme, J. M., & Popynick, M. (1993). Errorless compliance to parental requests: Treatment effects and generalization. *Behavior Therapy*, *24*(2), 209-226.

Everett, G. E., Olmi, D. J., Edwards, R. P., & Tingstrom, D. H. (2005). The contributions of eye contact and contingent praise to effective instruction delivery in compliance training. *Education and Treatment of Children*, *28*(1), 48-62.

Ford, A. D., Olmi, D. J., Edwards, R. P., & Tingstrom, D. H. (2001). The sequential introduction of compliance training components with elementary aged children. *School Psychology Quarterly*, *16*(2).

Larzelere, R. E., Sather, P. R., Schneider, W. N., Larson, D. B., & Pike, P. L. (1998). Punishment enhances reasoning's effectiveness as a disciplinary response to toddlers. *Journal of Marriage and the Family*, 388-403.

Norlin, C., Crawford, M. A., Bell, C. T., Sheng, X., & Stein, M. T. (2011). Delivery of well-child care: a look inside the door. *Acad Pediatr*, *11*(1), 18-26. https://doi.org/10.1016/j.acap.2010.12.008

Olson, L. M., Inkelas, M., Halfon, N., Schuster, M. A., O'Connor, K. G., & Mistry, R. (2004). Overview of the content of health supervision for young children: reports from parents and pediatricians. *Pediatrics*, *113*(6 Suppl), 1907-1916. https://www.ncbi.nlm.nih.gov/pubmed/15173461

Riley, A. R., Boshkoff, E. A., Neisius, A., & Freeman, K. A. (2016). A 4-minute video improves parents' instruction delivery to young children: A multiple-baseline investigation. *Clinical Practice in Pediatric Psychology*, *4*(4), 396-404. https://doi.org/10.1037/cpp0000146

Riley, A. R., Wagner, D. V., Tudor, M. E., Zuckerman, K. E., & Freeman, K. A. (2017). A Survey of Parents' Perceptions and Use of Time-out Compared to Empirical Evidence. *Acad Pediatr*, *17*(2), 168-175. https://doi.org/10.1016/j.acap.2016.08.004

Riley, A. R., Walker, B. L., Ramanujam, K., Gaultney, W. M., & Cohen, D. J. (2022). A Mixed-Method Investigation of Parent Perspectives on Early Childhood Behavioral Services in Primary Care. *J Behav Health Serv Res*, *49*(2), 134-148. https://doi.org/10.1007/s11414-021-09772-2

Riley, A. R., Walker, B. L., Wilson, A. C., Hall, T. A., Stormshak, E. A., & Cohen, D. J. (2019). Parents' Consumer Preferences for Early Childhood Behavioral Intervention in Primary Care. *J Dev Behav Pediatr*, *40*(9), 669-678. https://doi.org/10.1097/DBP.0000000000000736

Stephenson, K. M., & Hanley, G. P. (2010). Preschooler's compliance with simple instructions: A descriptive and experimental evaluation. *Journal of applied behavior analysis*, *43*(2), 229-247.

Taylor, C. A., Moeller, W., Hamvas, L., & Rice, J. C. (2013). Parents' professional sources of advice regarding child discipline and their use of corporal punishment. *Clin Pediatr (Phila)*, *52*(2), 147-155. https://doi.org/10.1177/0009922812465944

Williams, J., Klinepeter, K., Palmes, G., Pulley, A., & Foy, J. M. (2004). Diagnosis and treatment of behavioral health disorders in pediatric practice. *Pediatrics*, *114*(3), 601-606. https://doi.org/10.1542/peds.2004-0090




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